Certificate of Need Technical Advisory Committee Meeting
November 17, 2005
Seattle Airport Hilton Conference Center
Meeting Minutes

TASK FORCE MEMBERS PRESENT

Simeon Rubenstein, MD (Conference)
Debra Hatfield (Conference)
Jody Carona
Scott Faringer
Donna Goodwin
Bill Hagens
Eleanor Hamburger
Jean Pfeifer, RN
Palmer Pollock
Gil Rodriguez, MD
Sue Sharpe,
Jon Smiley

INTERESTED PUBLICE PARTIES

Vicki Austin
John Barnes
Jim Beaulainer
Gary Bennett
Cynthia Forland
Jo Isgrigg
Lisa Jeremiah
Jerry Kaufman
Tim Layton
Irene Owens
Gail McGaffick
Tom Piper
Edith Rice
David Weber

TASK FORCE MEMBERS ABSENT

Michael Kelly, MD
Scott Scherer
Torney Smith
Ele Hamburger

STAFF ATTENDEES

Nancy L. Fisher, MD
Linda Glaeser
Gary Fugere
Bev Skinner

Topic	Discussion	Outcome
Welcome Introductions Housekeeping Agenda Review	TAC members were introduced, housekeeping information was shared, and the agenda was approved.	
TAC Operations a. Review Charter b. Review Ground Rules c. Review the Decision Making Process d. Communications – web and e-mail e. Meeting Schedule	The TAC Operations Process was reviewed. Informational materials will be provided electronically prior to each meeting and hard copies available at the meetings. The HCA Website will be updated with additional reference material for CON committee members and the public. It was requested to use the HCA Medical Director e-mail box for correspondence. a. The TAC Charter was reviewed, the supporting relationship to the Task Force Charter, Tab B of the notebook, was noted. The Guiding Principles document, Tab D of the notebook, summarizes the framework from which the Task Force and the TAC are to work, as specified in the bill. JLARC study is going on simultaneously. JLARC will be providing a draft of their report to the CON Task Force at the end of May 2006. b. Meeting ground rules, Tab C of the notebook, were reviewed. c. Consensus decision making process, Tab C of the notebook, was reviewed for use during the work of the TAC and Task Force. d. A Communication Support Information sheet was provided. The TAC members were requested to use the HCA Medical Director e-mail box for correspondence. e. The meeting schedules of both the TAC and the Task Force were reviewed. The Task Force and TAC meeting schedules were developed in a manner to	hcaomd@hca.wa.gov

	allow for information to flow back and forth. A full report is due to the legislature on November 1, 2006.	
CON Background	Nancy Fisher, MD reviewed the background of CON from a national and state of Washington perspective. Materials referenced are contained in four (4) tabs of the notebook and on the web site: Tab I = '99 JLARC study (WA); Tab K = '05 Mercer background study (reviewed approximately 30 articles published since '99); Tab L = '04 FTC/DOJ report' and Tab M = American Health Planning Association position papers. Items highlighted included: • CON regulation originated in '64 in NY in effort to combat increasing health care costs related to surplus services. • Federal legislation in '74 provided funding to regional health planning networks in all states. • Federal legislation, and related funding, was repealed in '85; all states but LA had CON programs in place at that time, LA enacted legislation in '91. • Today 36 states have retained a CON program. All programs are "state fit" – only common coverage element across all 36 is nursing facilities. • The '99 JLARC study identified that there was not sufficient evidence to recommend repeal or retention, but suggested the consideration of reform or repeal (after determination of alternate methods for attaining policy goals for cost, quality, access and accountability) and an economic analysis to guide policy changes. A response/action was not undertaken by the Legislature at that time. • The '05 Mercer report confirmed continued diversity of structure/process, metrics, and outcomes between states.	Basic understanding of CON program/process

	• The FTC/DOJ study/report was undertaken to examine the potential role of competition in addressing the cost/quality/access challenges of the health care system. (The Executive Summary provides a primer on the health care system.) • The AHPA position papers provide a response to the FTC/DOJ report as well as discussion of the role of CON in health planning. These reviewed references are provided as a foundation for future discussions and development of recommendations for the improvement of the Washington State CON program/process.	
Presentations: Overview • CON • Licensure • Long-Term Care • Non-Hospital Surgical Setting	Presentations were given by DOH representative Gary Bennett and DSHS representative Irene Owens. (See power point presentation slides for the 10/06/05 Task Force meeting.) CON and licensure are related in Washington. DOH is preparing a summary of the past ten years of CON experiences. The Task Force and TAC can't look solely at the CON process due to the overlap of other pieces in the state of Washington.	A summary report will be provided at a subsequent session.
Group Values Identification Tool	The TAC members completed the tool. There are no right or wrong answers and the results will be useful in understanding the perspective of the group. The Task Force will also be doing this exercise.	A scatter chart with the results will be brought to the December 13 TAC meeting.

Current WA CON Process: expanded detail	A major topic area for the next meeting is: What is the current purpose and related general criteria for the CON process? Technical Advisory Committee members need a clear understanding of the scope of work for the Task Force and Technical Advisory Committee, understand the current limitations, and be familiar with the CON process in Washington in order to be able to make recommendations to the Task Force. However, the committee will need to view the process from a high level perspective, i.e., as to what is CON expected to accomplish, what areas it should apply to, and how should applicants be evaluated. Evaluation of the effectiveness of current internal workings will be a major portion of the JLARC study. It is necessary for CON to have a policy based decision structure to guide how the program is administered; in Washington that is RCW 70.38.015. Documents were reviewed which highlighted the current CON process as well as the changes since 1989. (See Attachment A)	Handouts will be expanded upon for discussion at the December 13 meeting.
Washington Supply, Expenditure and Outcome Data	Examples of data detail and sources related to Washington State were presented. Comparison data from other states will be provided during future discussions. Potential sources for future use include: www.statehealthfacts.org www.dartmouthatlas.org/data_tools.shtm www.doh.wa.gov/PHIP/reportcard/default.htm www.doh.wa.gov/Data/data.htm	Donna Goodwin will provide the TAC with a list of the Certified Home Health Agencies and Hospice and where they are physically located. Send an e-mail to HCAOMD@hca.wa.gov with any known contacts for data sources related to cost, quality, accessibility for health care facilities and/or services in

		Washington.
Discussion: CON relationship to supply, outcomes, and expenditures. Questions from Task Force.	Nancy Fisher, MD, presented four questions related to purpose and goal of the current CON process. (See Attachment B) The resultant points from the discussion will be presented to the Task Force at their 11/30/05 meeting. (See Attachment C-1 and C-2)	A summary will be sent to the TAC for review before presenting to the Task Force.
Welcome from HCA Administrator Steve Hill	Steve Hill expressed his appreciation for to the TAC for their participation.	
Elect two members to the Task Force	The TAC members submitted their ballots for the two Task Force "provider" member seats. Donna Goodwin and Mike Kelly, MD, declined to be nominees to be on the Task Force.	Absent members will be provided the opportunity to vote on representation to the Task Force. By close of business November 18, the TAC will be advised of the results.
Public Comments and/or Questions	Gail McGaffick spoke on behalf of the Home Care Association of Washington. She and the home care association believe in the CON program and want it to work, and want to improve and strengthen it.	

ATTACHMENT A

CHRONOLOGICAL LEGAL HISTORY
CERTIFICATE OF NEED LAWS
As of October, 2005

1971 State and regional health planning authorized. Certificate of Need ("CoN") required to be issued by DSHS for construction, improvement, acquisition or equipping projects by hospitals or nursing homes costing more than $100,000. **Chapter 198, Laws of 1971, 1st Ex. Sess.**

1979 Substantial revisions to CoN process to coordinate with federal National Health Planning and Resources Development Act. Amendments include: (i) establishment of state health coordinating council; (ii) a requirement to coordinate CoN program with federal law; (iii) specific delineation of new institutional health services subject to CoN review, including capital expenditures in excess of $150,000, construction of any new health care facility, any increase in bed capacity, development of any new health services, and any expenditures in excess of $150,000 in preparation for the development of one of the foregoing; (iv) establishment of specific criteria to be considered in the CoN review process; (v) establishment of a civil penalty for violation of CoN laws; and (vi) repeal of much of the 1971 law. **Chapter 161, Laws of 1979, 1st Ex. Sess.**

1980 CoN laws updated to reflect amendments to federal law by the Health Planning and Resources Development Amendments of 1979. Revisions include: (i) redefining capital expenditures to include donations and below—market transfers of health care facilities; (ii) establishment of $150,000 threshold for CoN review for hospital and nursing home capital expenditures, to be adjusted in accordance with an index established by DSHS; (iii) subjecting all capital expenditures resulting in substantial service changes to CoN review; (iv) subjecting most acquisitions of major medical equipment to CoN review; (v) subjecting new institutional health services requiring annual operating expenditures of at least $75,000 to CoN review; and (vi) exempting health maintenance organizations from most of the CoN review processes. **Chapter 139, Laws of 1980**

1982 Expenditure thresholds for CoN review raised to $600,000 for capital expenditure, $400,000 for major medical services, and $250,000 for new institutional health services; other technical amendments. **Chapter 119, Laws of 1982**

1983 Expenditure thresholds for CoN review raised to $1,000,000 (indexed to U. S. Commerce Department composite construction cost index) for capital expenditures and major medical equipment, and $500,000 for new institutional health services. Exemptions from CoN review created for capital expenditures for (i) communications and parking facilities; (ii) mechanical, electrical and HVAC systems; (iii) energy conservation systems; (iv) repairs necessary to maintain state licensure; (v) construction and equipment acquisition not related to direct provision of health services; (vi) land acquisition; and (vii) debt refinancing. Children's hospitals exempted from CoN process, but hospices and alcoholism hospital are included. Many other revisions to health planning and procedural requirements for issuance. **Chapter 235, Laws of 1983**

Removes Alcoholism hospitals from the definition of health care facility. **Chapter 41, Laws of 1983, 1st Ex. Sess**

1984 Sales, purchases and leases of existing hospitals subjected to CoN review. DSHS required to deny a CoN if the Hospital Commission ("Commission") does not recommend approval, unless the Secretary of DSHS provides the Commission with written reasons for overriding the Commission. **Chapter 288, Laws of 1984**

1988 A definition of Continuing Care Retirement Community (CCRC) is added. CCRCs are added to the definition of health care facility. It also excludes "type A" CCRCs from the definition of health care facility provided the CCRC meet certain criteria. **Chapter 20, Laws of 1988**

1989 Modifies statute provisions for an Adjudicative Appeal. Gives an applicant denied a CoN or whose CoN has been suspended or revoked the right to an administrative appeal under RCW 34.05, the Administrative Procedure Act. Removes reference to RCW 34.04 and the requirement that the hearing shall be held within 120 days of the request. Removes the provisions that the ALJ will review the initial decision and render a proposed decision to be considered by the Secretary or remand the back for further consideration. Removes statement that the Secretary's decision is subject to review by Superior Court. Removes the provisions that the department may establish procedures and criteria for reconsideration of decisions. **Chapter 175, Laws of 1989**

Substantial revisions to CoN process coincident with sunset of Commission and creation of Department of Health. Many capital expenditures by hospitals exempted from CoN, including expenditures for acquisition of major medical equipment and most new services. Those hospital activities still subject to review include: (i) construction or establishment of new health care facilities; (ii) sale, purchase or lease of any existing hospital; (iii) increases or redistributions of beds; (iv) implementation of tertiary health services; and (v) increases in number of dialysis stations. Requirement of CoN for most nursing home capital expenditures retained. All CoN review and issuance powers transferred to Department of Health. **Chapter 9, Laws of 1989, 1st Ex. Sess.**

1991 CCRCs are removed from the definition of health care facility. Exempts the nursing home portion of a CCRC from CoN review provided the CCRC meets certain criteria. If all these criteria are not met, CoN review is required. **Chapter 158, Laws of 1991**

Establishes an Ethnic Minority Nursing Home Bed Pool. The pool is limited to no more that 250 beds designed to serve the special needs of ethnic minorities. The pool is to be made up of beds that become available on or after March 15, 1991, due to (i) loss of license or reduction in licensed bed capacity if the beds are not otherwise obligated for replacement or (ii) Expiration of a Certificate of Need. Identifies specific criteria the nursing home must meet. Identifies specific ownership/operation criteria. Allows for the distribution of up to 100 beds from the bed pool in advance of the beds actually being in the pool. **Chapter 271, Laws of 1991**

Replaces the term skilled nursing facilities and intermediate care with nursing facility or nursing facilities. **Chapter 8, Laws of 1991, 1st Sp. Sess.**

1992 Allows a rural hospital to become a rural primary care hospital under the provisions of Part A Title XVIII of the Social Security Act Section 1820, 42 U.S.C., 1395c et seq. and reduce the number of licensed beds. If the rural primary care hospital subsequently wants to re-license itself as an acute hospital within 3 years, it may do so without CoN review. Allows a rural health care facility licensed under the provisions of RCW 70.41 to return to its rural acute care hospital licensure status within a period of 3 years without CoN review provided there has not been redistribution of beds between acute care and nursing home care and the facility has not been purchased or leased. Requires CoN review for a change in bed capacity of a rural health care facility. Requires CoN review for the redistribution of beds between acute care and nursing home care if the redistribution is effective for a period in excess of 6 months. Requires CoN review the provision of a tertiary health service offered in or through a rural health care facility. **Chapter 27, Laws of 1992**

1993 Adds a provision for nursing homes to voluntarily reduce the number of licensed nursing home beds (bank beds) to provide assisted living, licensed boarding home care, adult day care, adult day health, respite care, hospice, outpatient therapy services, congregate meals, home health, or senior wellness clinic or to reduce to 1 or 2 the number of beds per room. ("alternate use"). Requires the nursing home to give the department notice of intent to bank the beds within 30 days of the license reduction. Allows the nursing home to convert the original facility or portion of the facility back to no more than the previously licensed number of beds without being subject to CoN (except under 70.38.105(4)(d) -Cost over the threshold) provided the facility has been in continuous operation and it has not been purchased or leased. Requires a 1 year notice of intent to convert beds back to nursing home beds if no construction is necessary and 2 years notice if construction is required. Requires the department to count these beds as available when evaluating need. Beds banked under this provision may remain in the bank for 4 years with the possibility of a 4 year extension. Removes outdated reference to health plans. Adds the requirements that the department consider available nursing home beds in a planning area and the availability of other services in the community to be served by a nursing home when evaluating the need and cost containment criteria. Adds provisions for deeming the need for nursing

home beds to be met, if the application is to replace existing beds and the applicant is an existing licensee who proposes to replace them in the same planing area with the same or fewer number of beds. All other review criteria must be met as if the applicant were requesting new nursing home beds. Allows the beds of facility that closes entirely to be banked for up to 8 years. ("full facility closure"). Requires the department to consider them as existing beds for replacement purposes. Requires the nursing home to give the department notice of its intent to bank beds under this provision no later than 30 days after effective date of the facility's closure. **Chapter 508, Laws of 1993.**

1995 Modifications made to the "alternate use" bed banking provisions. Adds the ability of the a nursing home to bank beds for the purpose of "to otherwise enhance the quality of life for residents." Removes the requirement of CoN if converting the banked beds back has construction costs in excess of the review threshold. Requires written approval from the building owner if the owner has a secured interest in the nursing home bed rights. Adds provisions giving the right to any health care facility or HMO that meet certain criteria the option to present oral or written testimony and argument in an adjudicative proceeding. If the department subsequently decides to settle an appeal, the must inform these health care facilities and afford them an opportunity to comment, in advance, on the proposed settlement. Modifies the nursing home replacement provisions. Replacement of nursing home beds in the same planning area by an existing licensee who has operated the beds for at least 1 year is exempt from CoN review. The licensee must give notice of its intent to replace and is required to provide the department with certain information as required by rule. The replacement by anyone else requires CoN review. Modifies "full facility closure" bed banking provisions. Allows the licensee, or any other party who has secured an interest in the beds the ability to bank the beds for up to 8 years. Requires CoN review for any proposal to unbank the beds. However, the need is deemed met it the applicant was the licensee who had operated the facility for at 1 year immediately preceding the bed banking provided the beds are to be replaced in the same planning area. Allows the building owner (provided they have a secured interest in the beds and under very limited circumstances) the ability to complete a replacement project should the licensee be unable to do so. **Chapter 18, Laws of 1995, 1st Sp. Sess.**

1996 Modifies the exemption provisions from CoN review for repairs to or the corrections of, deficiencies in existing physical plants. Repairs, remodeling or replacement projects that are not related to one or more deficiency citations and are not necessary to maintain state licensure are not exempt from CoN review. Allows the renovation of dining areas, kitchen area, laundry and therapy areas without CoN review when the costs exceed the review threshold provided the licensee has operated the beds for at least 1 year prior to the project. **Chapter 50, Laws of 1996**

Changes the term osteopathy to osteopathic medicine and surgery. **Chapter 178, Laws of 1996**

1997 Modifies the conversion notice timelines for "alternate use" banked beds. The time is changed to 90 days when no construction is involved and 1 year when construction is involved. The term construction is defined as those projects with costs exceeding the CoN review threshold. Clarifies that a nursing home prior to converting the beds back must demonstrate the necessary criteria to be eligible to convert the beds. Adds a CoN review exemption for any health facility or institution conducted by and

for those who rely exclusively upon treatment by prayer or spiritual means in accordance with the creed or tenets of any well-recognized church or religious denominations. This exemption is also extended to any health facility or institution operated for the exclusive care of members of a convent or rectory, monastery, or other institution operated for the care of members of the clergy. **Chapter 210, Laws of 1997**

1998 Allows a one time CoN review exemption for bed additions to a residential hospice care center that received a CoN non-reviewability determination prior to June 1994. Defines "residential hospice care center" to mean any building, facility, place, or equivalent that opened in December 1996 and is organized, maintained, and operated specifically to provide beds, accommodations, facilities, and services over a continuous period of twenty-four hours or more for palliative care of two or more individuals, not related to the operator, who are diagnosed as being in the latter stages of an advanced disease that is expected to lead to death. **Chapter 322, Laws of 1998**

1999 The nursing home bed to population ratio is established in RCW. The ratio is set at 40 beds per thousand for residents 65+. Prohibits the program from accepting nursing home applications wanting to add bed capacity when the project is to be located in an overbedded planning area. The ratio section of the statute expires June 30, 2004. For those projects undergoing review, additional factors to be considered are outlined. **Chapter 376, Laws of 1999**

2000 DOH directed to revise the methodology applied to Certificate of Need applications for open heart surgery, therapeutic cardiac catheterizations and percutaneous translumenal coronary angioplasty. Provided direction on who should participate in the rule development. Required a report back to the health committees of the legislature on the development of the rules and provide the committees with a copy of the adopted rules. This section of statute expires December 31, 2000.**Chapter 59, Laws of 2000**

2000 Changes the definition of health care facility to include hospice care centers. Provides a window for the grandfathering of those facilities that were licensed either as a hospital (RCW 70.41) or a nursing home (RCW 18.51) that was providing the functional equivalent of a hospice care center. The act takes effect January 1, 2002. **Chapter 175, Laws of 2000**

2004 Provides an exemption for Critical Access Hospitals (CAH) from CoN review for the increase in licensed bed capacity or the redistribution of beds between acute care and nursing home care. If there is a nursing home licensed under RCW 18.51 within 27 miles of the CAH, the CAH is subject to CON review except for (i) CAHs that had designated beds to provide nursing home care, in excess of 5 swing beds, prior to December 31, 2003; or (ii) up to 5 swing beds. The CAH beds not subject to CoN are not counted as either nursing home beds or acute care beds. Provides reversion rights for the CAH to convert back to the type and number of licensed hospital beds it had when it requested critical access hospital designation. **Chapter 261, Laws of 2004**

ATTACHMENT B

Questions for CON Technical Advisory Committee
Re: CON Purpose and Goals

1. Given the remaining or current focus of the Washington State CON process, are the expectations, as set forth in RCW 70.38.015, being addressed by the CON program?

2. Are all the expectations in RCW 70.38.015 important to address? Are there additional expectations that should be addressed as public policy?

3. How could the CON Program best address the expectations, as set forth within RCW 70.38.015, for the ultimate realization of quality, accessible health care at a reasonable price?

4. Are there other avenues/pathways that could address the expectations, as set forth in RCW 70.38.015?

RCW 70.38.015 reads as follows:
It is declared to be the public policy of this state:

(1) That health planning to promote, maintain, and assure the health of all citizens in the state, to provide accessible health services, health manpower, health facilities, and other resources while controlling excessive increases in costs, and to recognize prevention as a high priority in health programs, is essential to the health, safety, and welfare of the people of the state. Health planning should be responsive to changing health and social needs and conditions. Involvement in health planning from both consumers and providers throughout the state should be encouraged.

(2) That the development of health services and resources, including the construction, modernization, and conversion of health facilities, should be accomplished in a planned orderly fashion, consistent with identified priorities and without unnecessary duplication or fragmentation;

(3) That the development and maintenance of adequate health care information, statistics and projections of need for health facilities and services is essential to effective health planning and resources development;

(4) That the development of nonregulatory approaches to health care costs containment should be considered, including the strengthening of price competition; and

(5) That health planning should be concerned with public health and health care financing, access, and quality, recognizing their close interrelationship and emphasizing cost control of health services, including cost-effectiveness and cost-benefit analysis.

ATTACHMENT C-1

CON

Outline for TAC recommendations 11-17-05

Policy

- Development
- Oversight
- Centralization
- Coordination across State Agencies

Definitions/Clarifications

- CON "fits" into healthcare delivery system
- Basic services all residents need access to
- Tertiary services
- Reimbursement/Incentives
- Financial provision for CON infrastructure

Accountability

- Oversight
- Monitoring

Data collection and analysis
Evaluation

ATTACHMENT C-2

TECHNICAL ADVISORY COMMITTEE---CON HB 1688

November 17, 2005 Committee Meeting

Recommendations regarding the purpose and goals of the Washington CON Process.

The TAC, in reviewing the present WA State purpose and goals for CON identified seven (7) key concerns: policy, accountability, tertiary services definition, reimbursement, leveraging WA State purchasing power for health insurance, a basic set of medical services to which Washington State residents should have access and agreement where the CON process fits in the larger picture of health care delivery.
It was felt that in order to strengthen the foundation on which to base the CON process, these issues need to be addressed before any changes are made to the WA CON process.

Policy
In the earlier process of CON, there was funding that supported a centralized system for policy formation and implementation. This way, each application, no matter the geographical location, type of application, etc. was assured the same process was being applied to each specific type of application. It was felt that these policies need to be evidenced-based and reviewed in order to respond to the changes in the health care arena. It was noted that the HCA by statute has the authority to be the overarching entity for implementation and coordination of health care policy. There formerly was a sub-cabinet on health, convened first by the Governor's office and then the HCA, which coordinated health care policy across the appropriate health agencies; however, this entity was not established in rule.

Accountability

Before any expansion or contraction of the CON process, a system of accountability, including but not limited to, standardized data collection, performance measures, monitoring, evaluation, quality assurance, reversal of CON certification (non-use, inappropriate use, provider quality of care concerns, etc) needs to be established.

Tertiary services
Studies reveal that the tertiary medical care and services are the highest cost areas in the field of health care. These services and care are highly specialized; require expertise beyond that of the primary care provider and specialized secondary care. In order to address cost, access and quality in a consistent pattern and meaningful manner, this parameter needs to be clearly defined for CON process.

Reimbursement
The reimbursement system is set-up to provide incentives for procedures and rewarding care of sick, more complicated individuals. While is not in the power of WA State to reform the national reimbursement system, reforms can be made on a state wide basis to reward the practice of evidenced- based medicine (P4P) or meeting national benchmarks, and not reimbursing for medical errors (for example, wrong site surgery), etc.

Government purchasing of health insurance
As the largest purchaser of health care, the State government could leverage it's purchasing power to influence the reimbursement systems, accountability of practitioners and providers. Additionally, partnerships with the private sector could potentially lead the change for quality and good health outcomes.

Agreement on where CON fits in the larger picture of health care delivery
In order to have a "best fit" for the WA State CON process, a discussion needs to occur around the influencing factors in the cost of health care delivery in Washington State. Who is providing the care? Who is getting the care? Who is paying for the care? Where is the care being provided? What kind of care is being delivered? How is the care being delivered? How has the delivery of care changed over time?

Basic set of medical services to which Washington States residents should have access
A discussion and decision needs to be made about what basic services do residents need to have access to in a relative close area (for example 25 mile radius). For the remaining medical services, prioritization on access could be based on medical evidence to determine regionalization of services. Some services would need to be concentrated to meet volume or other quality standards; some services would need to be only at Center of Excellence because of the highly specialized skills needed or the relative rarity of the service. Medical care site would also need to be looked at for appropriateness in outpatient versus inpatient. All of this would be driven by scientific evidence and would tie in closely with the definition of tertiary services, P4P and a defined process for policy making and oversight.